REVIEW OF ANCILLARY AND RELATED HEALTH SERVICES OF THE PROVINCE OF MANITOBA

By

Dr John Loxley
Dr Robert Chernomas
Dr Ardeshir Sepehri

Final Report
January 16, 2006

Table of Contents

	Page
1. Introduction, Terms of Reference and Acknowledgements	3
2. Ancillary and Related Programs: An Assessment	5
2.1 Prosthetics	5
2.2 Orthotics	7
2.3 Breast Prosthesis and Surgical Brassieres	9
2.4 Telecommunications Devices (TDD)	10
2.5 Orthopaedic Shoes	11
2.6 Hearing Aids for Children	12
2.7 Artificial Eyes	13
2.8 Eyeglasses for Seniors	14
2.9 Infant Contact Lenses	16
2.10 Insulin Pumps	17
2.11 Oxygen	17
2.12 Sleep Equipment	20
2.13 Synagis (Palivizumab)	23
2.14 Synvisc (Hylan G-F 20)	24
3. Overview of Main Problems	26
4. Recommendations	28
4.1 General	28
4.2 Specific Devices and Products	29
5. Estimated Costs of Proposals	33
6. Timing of the Implementation of Proposals	37
7. Summary of Annual Savings/Additional Costs	38

1. Introduction, Terms of Reference and Acknowledgements

This study was commissioned by the Department of Health in response to a number of concerns about the Ancillary Services it offers. These concerns are captured in the terms of reference of the study, which were as follows:

The Consultants will conduct an evaluation of the present services provided through the Ancillary Services, Provincial Drug Programs. The Ancillary Services include the following benefit provision programs:

1) Prosthetic Devices
2) Orthotic Devices
3) Breast Prosthesis and Surgical Brassieres
4) Telecommunication Devices
5) Orthopaedic Shoes
6) Hearing Aids for Children
7) Artificial Eyes
8) Eyeglasses for Seniors
9) Infant Contact Lenses

The evaluation of Ancillary Services must also take into consideration the review of additional benefit consideration for the following products/ areas:

1) Insulin Pumps
2) Home Oxygen
3) Sleep disorder and home ventilatory devices
4) Synagis
5) Synvisc

The Consultants will determine the strengths, weaknesses, and inconsistencies of public benefit coverage for the products/areas noted; and will provide recommendations on the development of a coordinated service provision model that may incorporate the delivery of benefits for all products/areas noted under one Program.

More specifically, evaluation objectives are:

To critique the current benefit models being used, and to comment on the methodology being presently used to provide benefits – both from an administrative point of view and a user payment viewpoint

To provide recommendations with appropriate costing on the development of a "new" Ancillary Program model that may incorporate benefit provision for all products/areas noted

To review, analyze, critique, and comment on the various benefit program user copays, deductibles, fee schedules, benefit plan design, processes, and decision making criteria, and, provide recommendations/rational re: approaches that should be followed as per the recommended model

To analyze each product/ area and provide comments on the feasibility/ practicality of addressing benefit provision through the modeling process developed

To provide cross jurisdictional charts, where possible, show what other provinces are doing with respect to the various benefit areas

To determine the stakeholders that are involved in the various issues, and comment on their possible role in the modeling developed

To determine issues and timelines that must be addressed to implement any Program change

Work will involve the consultant meeting with Manitoba Health staff, Regional Health Authority (RHA) staff, Program administrators, industry, and stakeholders. Provincial Drug Programs will set up initial contacts with Program staff and will provide ongoing support to set up further meetings as required, and will provide a work setting within Manitoba Health.

The timeline for the study was extremely tight, only five weeks, including the Christmas and New Year's holiday period. This limited the ability of the consultants to interview as many people as would otherwise have been desirable and it severely limited their ability to conduct any systematic, comprehensive quantitative analysis. Nonetheless, given this tight timeline, we believe that the major issues have been identified and some plausible solutions to problems have been offered. Inevitably, many details remain to be addressed concerning implementation of the recommendations, but Health staff are much better placed to address these than are short-term outside consultants.

This report draws heavily on the insights of staff in Health, the RHAs, RHAM and the private sector in both written and oral submissions. We acknowledge this generous assistance and the co-operative and constructive way in which it was given. We remain responsible, however, for what follows.

2. Ancillary and Related Programs: An Assessment

In what follows we outline the various programs offered under Ancillary Services as provided for in The Health Services Insurance Act and the Prosthetic, Orthotic and Other Medical Devices Insurance Regulation. We also review those programs/services/devices outlined in the terms of reference which are not covered by the Act and Regulations, but which it might be appropriate to cover on grounds of consistency. We outline for each, where appropriate, the purpose of the program, the benefits provided, who bills for and supplies the devices in question, who authorizes them and monitors their use, how many patients there are and at what cost to the Province. Policies and practices in other provinces are examined where possible. Finally, the main issues that the specific programs seem to raise are discussed. This information provides the basis for the general overview of issues needing to be addressed, in the next section, as well as providing the rationale both for the recommendations in Section 5, and for the detailed costing of recommendations in Section 6.

2.1 Prosthetics

Program Purpose

To provide funding assistance to people of all ages who have a chronic physical disability and require an assistive device to improve their ability to function in daily activities.

Benefits Provided

The Prosthetics Limb Program pays 100% of eligible items based on a fee for service schedule negotiated with the Manitoba Orthotics and Prosthetics Association (MOPA). There are no deductibles or co-payments. One device per limb is provided every two years.

How Billed

Claims are submitted by suppliers.

Suppliers

There are a number of privately owned suppliers all of whom are certified prosthetists.

Diagnosis, Compliance and Monitoring

Patients are admitted to the program under a prescription from their physician, after a complete diagnosis. Any ongoing monitoring is the responsibility of the physician.

Patients

There are approximately 750 to 800 patients being billed for under the program each year, and a 'stock' of between 9-10,500 beneficiaries.

Cost

The cost of the prosthetics program was$1.98 million in 2004/05 and is expected to reach $2.1 million in 2005-06.

Other Provinces

Nova Scotia, Saskatchewan and Quebec pay 100% of an approved fee schedule for prosthetics. Alberta and Ontario require a 25% co-payment (up to a maximum co-payment of $500 per family p.a. in Alberta for these and all other devices) while BC requires a 30% co-payment with a minimum-maximum deductible range of $800-$2,000.

Issues

The program is largely a bill payment program. The Department has little if any provision for program management to address issues of accessibility, utilization analysis, impact or equity or to assess the efficacy of different devices. There are questions about the substitutability of different devices and about the appropriateness of the technology being used in the devices covered by the fee schedule. There is also no provision for appeals of decisions made by Ancillary Programs with regard to funding.

The current prosthetic fee schedule was set in 2001, apparently based on 1998 prices. MOPA frequently asks for fees to be increased, claiming that certified prosthetists are subsidising the program. MOPA promised to submit an updated fee schedule to Health in 2005 but we have not seen this. The current fee schedule did provide for a 30% profit margin per limb which might explain why complaints about fees have not been greater, since that margin per limb would, presumably, translate into a much higher margin on capital invested. We also have no idea of what has happened to material costs since 2001 and it cannot be assumed that these have all necessarily increased, given what has been happening to prices of electronics and related products. What we do know is that total costs of the program have risen by 77% since 1999-2000 while total number of beneficiaries has risen by only 8.7%. The difference must be due to a combination of the fee increase or to the use of more complicated/expensive devices or the fitting of more devices per person. Tardiness in adjusting fees may have helped cap the program's costs, but average fees per patient have risen significantly anyhow. Moderating fee increases might be a good thing, but the key is to do so without prejudicing the availability of prosthetic services in the Province. A more in-depth study of why average costs per patient have exceeded the fee increase is also needed.

MOPA seems to suggest that prosthetics (as well as orthotics) are being fitted by non-certified suppliers, while regulation 219/96 provides that devices would only be funded when fitted by certified practitioners.

The current approach of paying 100% of the fee schedule seems warranted and we see no need for co-payments and deductibles for this program which, we are informed by the Department, yields $11 in benefits for every $1 in cost by enabling patients to be more active in their daily lives.

2.2 Orthotics

Program Purpose

To provide funding assistance to people of all ages who have a chronic physical disability and require an orthotic device to improve their ability to function in daily activities.

Benefits Provided

The Orthotics Program pays 100% of eligible items based on a fee for service schedule negotiated with the Manitoba Orthotics and Prosthetics Association (MOPA). There are no deductibles or co-payments. One device per limb is provided every two years.

Patients

There are approximately 12,200 to 13,500 patients being billed for under the program each year.

Cost

The cost of the orthotics program was $5.0 million in 2004/05 and is expected to reach $5.5 million in 2005-06.

Other Provinces

Nova Scotia, Saskatchewan and Quebec pay 100% of an approved fee schedule for orthotics. Alberta and Ontario require a 25% co-payment while BC requires a 30% co-payment with a minimum-maximum deductible range of $800-$2,000.

Issues

The orthotics program is largely a bill payment program. The Department has little if any provision for program management to address issues of accessibility, utilization analysis, .impact or equity or to assess the efficacy of different devices. There are questions about

the substitutability of different devices. There is also no provision for appeals of decisions made by Ancillary Programs with regard to funding of orthotics.

The current orthotics fee schedule was set in 1995, apparently based on 1993 prices. MOPA frequently asks for fees to be increased, claiming that certified orthotists are subsidising the program. MOPA promised to submit an updated fee schedule to Health in 2005 but we have not seen this.

In spite of this, the orthotics program is the most expensive portion of Ancillary Programs, accounting for 62% of total spending. It is also growing rapidly, by about 150% between 1999-2000 and 2005-06. The number of beneficiaries has grown by 100% during this period, suggesting that the average cost of orthotics has risen by 50%. It may be that orthotists are fitting more expensive orthotics to compensate for lower margins. It may also be that the cost of orthotics, more so than prostheses, has fallen in recent years with the development of mass-produced braces using improved materials, thereby compensating suppliers for fees not adjusting with inflation: we simply do not know.

MOPA argues that orthotics are being fitted by non-certified suppliers, while regulation 219/96 provides that devices would only be funded when fitted by certified practitioners. Health has, in fact, given billing numbers to a number of uncertified suppliers of orthotics and for reasons that are not clear. Some of these suppliers apparently have ties to physicians who are called upon to prescribe orthotics, raising issues of possible conflict of interest.

There is a feeling that orthotics are prescribed far too liberally and for purposes that should not be covered (e.g. sports injuries) or covered by others (e.g. Workers Compensation Board (WCB) for work related wrist injuries) but there is no firm evidence on this.

Non-certified orthotists receive a lower fee than certified orthotists but MOPA argues that proper fitting of even mass-produced devices, needs to be done by certified orthotists. MOPA also argues that non-certified orthotists prescribe more expensive braces than patients actually need.

Very little is known about the structure of billing for orthotics and the (3) staff of Ancillary Programs, who do an excellent job in handling so many claims manually, do not have time to undertake analysis of billings. Yet a systematic analysis is really needed to guide future policy. Insufficient time was allowed in this study for a comprehensive review of billings. A sample of 727 billings from November-December last year totalling $225,500, however, shows that certified orthotists accounted for 83% of billings by value and 74% by number. Over 31% of billings were, however, for less than $100, totalling only $14,300 or only 6.3% of total billing by value. About a half of all billings by non-certified suppliers were under $100, accounting for over 13% of billings by value, and about a quarter of those by certified suppliers were under $100 accounting for just under 5% of their billings. The vast majority of billings by non-certified suppliers were for knee braces and wrist supports.

2.3 Breast Prosthesis and Surgical Brassieres

Program Purpose

To provide funding assistance to people who have had a mastectomy towards the purchase of prostheses and surgical brassieres.

Benefits Provided

The program provides two prostheses (single mastectomy) and four prostheses (double mastectomy) every four years, and two brassieres annually. The maximum benefit is $153.50 per prosthesis and $12.30 per brassiere. The patient pays the difference between these amounts and the costs of prostheses, which range from $20 to $420, and the cost of brassieres which range from $12.30 to $110.

How Billed

Claims are submitted by the patients.

Suppliers

There are at least 15 privately owned suppliers.

Diagnosis, Compliance and Monitoring

Patients are admitted to the program under a prescription from their physician.

Patients

There are approximately 1,150 patients claiming under the program each year.

Cost

The cost of the breast prostheses/surgical brassieres program was$142,500 in 2004/05 and is expected to reach $145,000 in 2005-06.

Other Provinces

Ontario covers prostheses only and requires a 25% co-payment. Albert also requires a 25% co-payment and the maximum amount is $322. BC Pharmacare provides prostheses assistance up to $350 every two years and two post-operative brassieres. Quebec pays $200 per prosthesis every two years and cheques are sent out automatically to patients after first claim is made.

Issues

There are four issues here: the first is that the maximum amount paid to patients has not been increased since 1992: the second is that payments for brassieres are too small to warrant the administrative expense; the third is that the Department has to deal directly with many clients for billing purposes and the fourth is that there is an inconsistency in the treatment of this kind of prosthesis compared to all other prostheses funded by the Province in that patients pay a co-payment.

2.4 Telecommunications Devices (TDD)

Program Purpose

To provide assistance toward the purchase of a TTY/TDD for persons who are profoundly deaf or speech impaired.

Benefits Provided

The program provides one device every 60 months. Clients pay a $75 deductible and 20% of cost after deductible. The maximum benefit paid by the program is $428. The cost per device is between $329 and $730.

How Billed

Claims are submitted by the patients.

Suppliers

There appear to be two privately owned suppliers.

Diagnosis, Compliance and Monitoring

Patients are admitted to the program after proof of hearing or speech impediment is provided by their physician, audiologist or otolaryngolist.

Patients

There are about 30 beneficiaries of this program each year.

Cost

The cost of the telecommunications program was $8,200 in 2004/05 and is expected to reach $8,900 in 2005-06.

Other Provinces

Ontario will pay 75% up to a maximum of $400.

Issues

There are three issues here: the first, and most important one is whether or not patients should be subjected to a deductible and a co-payment for a device which is as important to them as a prosthesis: we think not. A second issue is that prices have not been adjusted since 1992. A third is whether billing should be direct by suppliers.

2.5 Orthopaedic Shoes

Program Purpose

To provide assistance toward the purchase of orthopaedic shoes for children under 18 who have foot deformities.

Benefits Provided

The program pays 50% of the cost of shoes, according to a schedule, with custom made shoes having a maximum benefit of $139. The client is eligible for two pairs of shoes per year.

How Billed

Claims are submitted by the patients.

Suppliers

There appear to be two privately owned suppliers.

Diagnosis, Compliance and Monitoring

Patients are admitted to the program on the basis of a prescription from a medical practitioner. No further prescriptions are required thereafter.

Patients

There were 120 beneficiaries of this program in 2004-05 but only 36 in the previous year and an anticipated 54 this year.

Cost

The cost of the orthopaedic shoes program was $4,400 in 2004/05 and is expected to be less than half that in 2005-06.

Other Provinces

Ontario does not cover orthopaedic shoes. Alberta covers one pair p.a. with a 25% deductible.

Issues

There are three issues here: the first, and most important one is whether or not patients should be subjected to a co-payment for a device which is as important to them as a prosthesis: we think not. A second issue is that prices have not been adjusted since 1992. A third is whether billing should be direct by suppliers.

2.6 Hearing Aids for Children

Program Purpose

To provide assistance toward the purchase of hearing aids for children under 18 who are hearing impaired.

Benefits Provided

The program allows one device per ear every 48 months. The client pays a $75 deductible plus 20% of the remaining costs, according to a fee schedule. The maximum benefit level for digital technology is $1,800 per ear and that for analog is $500 per ear.

How Billed

Claims are submitted by the supplier.

Suppliers

There appear to be several privately owned suppliers.

Diagnosis, Compliance and Monitoring

Patients are admitted to the program on the basis of a recommendation from an audiologist; no prescription is required.

Patients

There are about 100 beneficiaries of this program each year.

Cost

The cost of the hearing aid program was $239,000 in 2004/05 and is expected be $217,000 in 2005-06.

Other Provinces

Ontario covers up to 75% of cost, subject to a maximum amount of $500 per aid. Alberta also covers up to 75% subject to a maximum amount. Quebec appears to provide them free for people of all ages.

Issues

The issue here is one of simplifying the benefit package by designating hearing aids as a Category 2 device and applying a $100 deductible only.

Or

The issue here is whether or not patients should be subjected to a deductible and a co-payment for a device which is as important to them as a prosthesis: we think not.

2.7 Artificial Eyes

Program Purpose

To provide assistance for people who require artificial eyes.

Benefits Provided

The program pays about 70% of the cost of the device subject to a maximum allowable in a fee schedule, with the patient being responsible for any additional costs. The client is eligible for one device every five years.

How Billed

Claims are submitted by the supplier.

Suppliers

There appear to be several privately owned suppliers.

Diagnosis, Compliance and Monitoring

Patients are admitted to the program on the basis of a prescription from a medical practitioner.

Patients

There were 207 beneficiaries of this program in 2004-05 and 204 are expected this year.

Cost

The cost of the artificial eye program was $39,400 in 2004/05 and is expected to be about the same in 2005-06.

Other Provinces

Ontario covers up to 75% of cost, subject to a maximum amount. So does Alberta up to a maximum of $1,300.

Issues

The only issue here is that of consistency of programs.

2.8 Eyeglasses for Seniors

Program Purpose

To provide assistance towards the purchase of eyeglasses for persons who are 65 and older.

Benefits Provided

The program pays 80% of the cost of eyeglasses subject to a maximum allowable in a fee schedule. The client pays a $50 deductible and the remainder of the costs. The client is eligible for one pair of eyeglasses every three years, or more regularly if the prescription changes.

How Billed

Claims are submitted by the patient.

Suppliers

All dispensing opticians can act as suppliers.

Diagnosis, Compliance and Monitoring

Clients are admitted to the program on the basis of a prescription from a licensed optician.

Patients

There are between 18,000 and 19,000 beneficiaries of this program.

Cost

The cost of the seniors' eyeglasses program was $683,800 in 2004-05 and is expected to be $708,000 in 2005-06.

Other Provinces

No other province provides this type of assistance.

Issues

There are a number of issues here. The first is should Manitoba be offering a program no other province offers? We think it should and the popularity of the program is evident. The second issue is that the average claim in this program is quite low, at about $37 - almost a half of all claims being for less than $37 - and claims are submitted by individual clients. The problem is that Health has to write cheques which cost more than $37 in administration. This is closely related to the third issue, which is that there has been no price adjustment in this program since 1982. What is keeping claims so small is less the deductible and co-payment than the maximum allowable in the fee schedule. At the moment, and based on a sample of claims from December 2005, the average cost of eyeglasses and related products by claimants was $350. This means that the Province is paying only 10.6% of the total cost and the client 89.4%. On the other hand, bringing prices up to date would expand the program significantly, a program that has not grown since at least 1999 which would, in turn, raise issues of sustainability. If the fee schedule were to represent actual costs, then the patient would pay $50 plus 20% of the average cost minus the deductible, i.e. $50 + {20% of ($350-$50 = } $60 = $110 in total and the Province would pay the difference of $240 on average. The cost of the program would then be in the region of $4.4 million. Thus, the maximum amount allowable in the fee schedule is, on average, only 15.4% of what it would be if full current costs were allowed. The fourth issue here is that of consistency of programs, in terms of deductibles and co-payments.

2.9 Infant Contact Lenses

Program Purpose

To provide assistance for infants with congenital eye disorders that can only be corrected by the use of contact lenses.

Benefits Provided

The program pays 100% of the cost to a maximum allowable in a fee schedule, with the client being eligible for one lens per eye per lifetime.

How Billed

Claims are submitted by the supplier.

Suppliers

There is currently only one supplier.

Diagnosis, Compliance and Monitoring

Patients are admitted to the program on the basis of a prescription from a medical practitioner.

Patients

There was only one beneficiary of this program in 2004-05.

Cost

The cost of the infant contact lens program was $200 in 2004/05.

Other Provinces

Ontario covers up to 75% of cost, subject to a maximum amount?

Issues

The only issue here is whether or not the program is needed.

Costing of Recommendations

Zero.

2.10 Insulin Pumps

We were asked to examine the desirability of adding insulin pumps to Ancillary Programs.

It appears that, continuous subcutaneous insulin infusion, or the insulin pump, is a safe and more convenient alternative to insulin injections 'for motivated patients who are adequately trained and supported by a specialized team' (AETMIS Quebec, report, December, 2004, quoted in Health Manitoba briefing paper). Only a small proportion of patients would actually benefit from the resulting improvement in glycemic control. In short, 'the pump is effective in a minority of carefully selected patients who are conscientious, serious, motivated and disciplined'. There are, however, fewer than 10 trainers in Manitoba for the 92 patients who have bought pumps privately. The long term efficacy of pumps, however, is also simply not known.

What is known is that there are over 80,000 diabetics in the Province who could, potentially, be users of the pump, which costs $6-7,000. In Quebec, it appears that the annual cost of using pump therapy is $4,756 more than that of multiple injection therapy.

We would concur with the recommendations of the Advisory Note for the Minister for Health on Insulin Pumps, dated November 14, 2005 and, accordingly, recommend against extending benefits to pump users at this time and until adequate research results are available to demonstrate their efficacy.

2.11 Oxygen

Program Purpose

To supply oxygen to patients with lung diseases which cause chronic hypoxia. The Home Oxygen Program (HOP) supplies oxygen through concentrators (and reserve tanks) and is administered by the RHAs through the Home Care Program. The Portable Oxygen Program (POP) provides patients with compressed air or liquid oxygen and is administered through the Pharmacare Program.

Benefits Provided

Under the HOP, all costs are met by the Home Care Program. The concentrator costs approximately $1,500 and with annual repair and maintenance (about $150), should last at least five years. Under the POP patients are subject to the normal Pharmacare deductible. The capital cost of the liquid oxygen system is around $3650, on average, and lasts for about five years, and transportation costs around $730. There are no co-payments. Many POP patients will have their non-Pharmacare costs covered to some degree by third party insurance.

How Billed

Claims are submitted by the supplier for the HOP and by the patient for the POP.

Suppliers

All suppliers are private and the supplies for the HOP are tendered by RHAM. For the POP, individual patients make their own arrangements with suppliers and supplies are not tendered.

Diagnosis, Compliance and Monitoring

Under the HOP, the patient's physician orders a blood test which is forwarded to Home Care. The blood test is then evaluated by a specialist in the region, an Approved Regional respiratory Authorizer, in accordance with guidelines laid down by the Department of Health. These guidelines are arrived at by a provincial advisory committee comprising representatives of the Department, RHAM, RHAs, RANA (the supplier to the HOP), Health Sciences Centre and Deer Lodge. Monitoring of the use of equipment and on-going evaluation of need is the responsibility of the Home Care Program.

Patients are admitted to the POP under a prescription from their physician, without the requirement of a specialist referring to any provincially established guidelines. Any ongoing monitoring is the responsibility of the physician.

Patients

There are approximately 1,000 patients on the HOP, with an average age of 71, and about 1,200 patients on the POP, of whom about 300 are also on the HOP.

Cost

The cost of oxygen in the HOP was $1.1 million in 2002/03 and $1.1 million in the POP ($1.3m in 2004-05).

Other Provinces

Home oxygen programs are offered by Alberta, Saskatchewan, BC, Quebec and Ontario, to a limited extent by New Brunswick, and by Veterans' Affairs and NIHB. With the exception of New Brunswick, these programs all cover both stationary and mobile oxygen as well as oxygen conservation devices based on medical eligibility criteria. Vendors are certified and subject to minimum service requirements and uniform maximum zone pricing and clients can chose between them.

New Brunswick limits coverage to those eligible over 65 years of age and limits access to concentrators and conservation devices through RHAs, under a single source contract.

In BC, Alberta, Quebec and New Brunswick, benefits are provided at no charge to the client. In Ontario, this is also the case for seniors and the disabled but others pay 25%. In Saskatchewan, clients pay a percentage of the monthly concentrator rental and 50% of the oxygen cost. In Newfoundland, only social assistance recipients are eligible.

Issues

The main issues here appear to be those of consistency between the HOP and the POP programs, the monitoring of the programs, the use of liquid oxygen in the POP and coverage of oxygen savings devices. A further issue is whether oxygen should be brought entirely under Ancillary Programs in the Department of Health.

Consistency is an issue because the standards set and the mechanisms used to access the programs appear to be different. Access to the HOP appears to be more stringent, governed by a specialist on the basis of tests commissioned by a physician. If the clinical benchmark for access to the HOP is a reasonable one, why should that not become the benchmark for access to portable oxygen too? And if it is reasonable to provide oxygen in the home free, as we deem it to be, why should those patients be subject, potentially, to a Pharmacare deducible when they use oxygen on leaving the home? Furthermore, it is not clear to us why any patient not requiring home oxygen should be given access to oxygen once they leave the home. If there is a case for this, then patients should be screened through procedures identical to those used for the HOP. If there is not, then only HOP patients should have access to the POP and, ideally, for reasons of consistency and fairness, on the same terms as home oxygen. This would suggest that running the POP through Pharmacare is not warranted and that it should be phased out as existing POP patients cease to use the program.

It appears that **monitoring** the HOP could be improved, ensuring that contracted service standards are met, in the process improving efficacy of devices, safety of patients and possibly lowering program costs. In BC, close monitoring has, reportedly, resulted in more efficient use of machines, greater safety and a 20% drop in assessed need to use home oxygen.

It is also not known how effective is physician monitoring of the POP, but the suggestion is that it too leaves a lot to be desired.

In short, there appears to be a need for more respiratory nurses and respiratory technicians to be hired to visit patients, the suggestion being that they would improve clinical practice and, at the same time, possibly save money.

Liquid oxygen is 3 to 4 times as expensive as the concentrator/cylinder alternative, costing about $915 per month versus $248 (based on usage of 183 kgs of liquid per month), and is considered suitable only for the highly motivated requiring high oxygen flow rates. At the moment, however, clinical needs appear to be less important than supplier driven demand in the provision of liquid oxygen. There appears to be a need for tighter control over access to liquid oxygen based on clear medical guidelines.

Pharmacare does not currently cover the use of oxygen **conservation devices**. These devices cost between $700 for a pneumatic device and $1,200 for an electric one. Whether or not these devices would actually save money would depend upon monthly oxygen use and per cent conserved, but in principle, it makes no sense not to cover them.

Finally, we see no obvious advantages in bringing oxygen into **Ancillary Programs**. The Home Care/RHA institutional structure seems appropriate for the client/clinical base and adding another layer of administration seems redundant.

2.12 Sleep Equipment

Program Purpose

To provide equipment and supplies to patients suffering from Obstructive Sleep Apnea (OSA), to enable them to function more normally. At the moment, patients qualify after undergoing a Level 1 Sleep Test/Study at either St Boniface Hospital or the Health Sciences Centre. Equipment and supplies, and support and training in their use, are provided by the Home Ventilatory Assistive Devices Services (HVADS).

Benefits Provided

HVADS provides equipment and supplies free of charge to all clients. 90% of patients use CPAP machines costing from $530-$650 while 10% use BiPAP machines costing from $2,600 to $5,350. Annual supplies cost approximately $120 per patient.

Patients

There are approximately 5000 patients registered with HVADS, and a three month waiting list of 217 who have had level 1 sleep tests but are awaiting equipment. There is also a waiting list for level 1 tests of around 3,000. There are plans, however, to expand the number of level 1 sleep studies/tests by 800 per year and to bring into the public sector level 3 tests. These are currently undertaken by the private sector for patients who then have to purchase their own machines and supplies. This will greatly reduce the current waiting lists for studies/tests, by 1,800 a year, but it will also greatly increase the demand for equipment and supplies.

Cost

Total cost of the machines and supplies in 2004/05 was $2.3 million funded through the Manitoba Specialized Equipment Fund but in the current year the Winnipeg Regional Health Authority (WRHA) received only $2 million in global supply costs to cover these items. If current expansion plans for studies/tests go forward, the cost of machines and supplies will increase significantly.

Other Provinces

Only Manitoba covers both machines and supplies. Saskatchewan covers equipment but not supply costs; Ontario covers 75% of equipment costs to a maximum of $1,200 and Alberta and BC cover neither.

Issues

The main issues are how best to provide funding for the large number of patients soon to be tested and how to ensure that equipment provided patients is actually used. The two are intimately linked.

While there is a large, unmet demand for equipment, **a high proportion of equipment that has already been distributed remains unused or under used**, perhaps as high as 52% is one estimate we were given. It is imperative that this problem be dealt with before the program is expanded, for two reasons: first so that better use can be made of available equipment either by existing patients or by new ones and, secondly so that the government can avoid throwing good money after bad. The solution that is being proposed by the Department and the WRHA is to institute a $250 deposit which would be refundable within one year if patients decide not to use the machine. In the short-run this idea is a sound one and we support it. In the medium to long-run, however, we believe that the building of smart cards into the machines to track their use is preferable. As these new machines replace the old ones, the refundable deposit should be dropped. Tracking of the use of machines, to ensure that patients use them at least 4 hours a night, five nights a week, would make it very clear who was not using the machines as required for them to work and would suggest the need for remedial action or repossession and redistribution of the machine. In the meantime, it is imperative that steps be taken to increase the utilization of machines or, where this is demonstrated on clinical grounds to have failed, to repossess them, perhaps by offering a cash incentive.

Current proposals do not call for the introduction of user fees, co-payments or deductibles beyond the $250 deposit. While this is a more generous public policy position than that taken by Alberta and BC, and more or less generous than that of Ontario, depending on the cost of machines, we are persuaded it is a reasonable one, given the economic and social costs of sleep apnea.

The **additional equipment costs** of expanding the sleep program (net of the $250 deposit) are intended to be met out of the Federal Wait Time Funding deposited in the Fiscal Stabilization Fund. A total of $825,000 has been allocated for this. We believe this underestimates the likely cost of equipment in the expanded program. The reason for this is that an annual addition of 1,800 machines is anticipated, suggesting an average cost per machine of $825,000/1800 = $458, plus the $250 deposit = $708. To begin with, this is low relative to the weighted average cost of machines which is closer to $930, suggesting a possible shortfall in funding of about $400,000 (1,800 x $930 = $1,675,800, less $250 x 1,800 = $450,000, = $1,225,800, less the $825,000 provided for, = $400,800).

More importantly, the average costs of machines, as laid out in the 'Benefits Provided' section above, are current public sector costs of machines, whereas the reform proposals intend the machines to be purchased directly from private suppliers who would also charge for educating and training patients in their use. These suppliers would charge much more than the current public sector costs, somewhere between them and the current price paid by individuals which, we are told, is about double the public sector costs. Since no decision has been made on how supplies would be obtained from the private sector, by agreed prices, quotations or tender, it is not possible to forecast what the prices would likely be. At current, individual, prices, however, the program would be under funded by as much as $1,000,000 (1800 x $1,300 = $2,340,000, less $250 x 1,800 = $450,000, = $1,890,000, less the $825,000 provided for, = $1,065,000, no provision being made for machines and hence, deposits, being returned or for the use of BiPAP machines).

The additional machines, therefore, are under provided for by between $0.4 and $1.0 million if they are to be purchased directly from the private sector. The current annual additions to machines of 1,200 would, however, also produce deposits of $0.3 million, to be deducted from the shortfall (there are also plans to raise this total by 800 this year, which would bring in a further 800 x $250 = $200,000 in future, but as yet funding for these is not guaranteed). On our proposals, however, all deposits would be abolished once smart cards have replaced existing technology.

There is, however, a question of the wisdom of transferring the functions of machine supply and education and training directly to the **private sector**. No evidence was presented in the background documents suggesting this would be cheaper and there are grounds for thinking the opposite might be the case, given current prices paid by individuals. Furthermore, no evidence was presented showing that this might be more effective in terms of machine usage/effective treatment and, pending the introduction of smart cards, the private sector doesn't appear to argue this either. Yet education and training in the use of equipment appear to us to be fundamentally clinical issues which go to the heart of equipment usage and, hence, should remain in the public sector. It seems that the proposal shifting these functions to the private sector was arrived at more by way of compensation for bringing level 3 tests into the public sector, but this reasoning is not persuasive.

Retaining the supply of equipment and the associated education and training, in the public sector would mean that costs additional to ones allowed for in current proposals would be incurred for processing the $250 deposits and for administering equipment and supplies inventories. These will not, however, be large and would probably be offset by the avoidance of paying the private sector higher prices for equipment.

There is also the question of whether or not sleep equipment and annual supplies should be brought into **Ancillary Programs**. We would argue against this on the grounds that sleep programs have a well established and working institutional base in the hospital system and bringing these elements into Ancillary Programs would not accomplish any obvious efficiencies. Hospitals have well established systems for billing additional costs to patients and would be well equipped to handle those aspects of any proposals

forthcoming and the equipment and supplies in question are secondary to the expertise needed to use them properly.

2.13 Synagis (Palivizumab)

Program Purpose

To supply premature babies with a prophylaxis against respiratory syncytial virus (RSV). Synagis is a plasma protein product.

Benefits Provided

Synagis is provided at no cost to the patient/family.

How Billed

Currently the Canadian Blood Service (CBS) is billed by the supplier. Manitoba reimburses the CBS through contributions to its budget.

Suppliers

Abbott Laboratories is the sole supplier of Synagis in Canada. Abbott distributes the product direct to hospitals and physicians (initial treatment is usually in the hospital, then in out-patient clinics and finally in doctors' offices).

Diagnosis, Compliance and Monitoring

Initial diagnosis is conducted by a pediatrician.

Patients

In 2004-05, there were 181 patients in Manitoba using Synagis.

Cost

The cost per baby was almost $5,500 in 2004-05 for a total cost of $995,500, up from $4,700 per baby and $724,000 in total in 2000-01.

Other Provinces

All provinces supply Synagis free to patients/families, paying through the CBS.

Issues

The main issue here is that the CBS does not feel it is appropriate for it to handle this product as it does not fall within the domain of transfusion medicine. The question is how should it be handled, through Pharmacare, through Ancillary Programs or through some other mechanism?

Given the central role of hospitals in the dispensing of the product, we do not feel that Pharmacare is a suitable vehicle for handling Synagis and neither do we feel that it is appropriate to charge a deductible for this product.

Neither do we see any advantages in running the billing for Synagis through Ancillary Programs. Rather, it would be easier and simpler for billing to shift from CBS to the Provincial Blood Program in whose budget Synagis is currently provided for.

There is, however, some concern about the ease with which the product is dispensed. There appears to be a need for a more careful review by specialists of each patient being considered for Synagis, within guidelines for best practices that need to be drawn up by the Province. BC and Nova Scotia have already moved in this direction.

2.14 Synvisc (Hylan G-F 20)

Program Purpose

To provide joint lubrication for patients suffering from osteoarthritis of the knee. Synvisc is a biotechnology product, available on a non-prescription basis and administered by physicians.

Benefits Provided

No benefits are currently provided to users of Synvisc, who pay approximately $400 for the treatment.

Suppliers

The product is produced by Genzyme Biosurgery.

Diagnosis, Compliance and Monitoring

Physicians diagnose the need for this treatment.

Patients

It is not known how many patients use Synvisc as pharmacists are not required to put the information on DPIN. It appears that 165 prescriptions were registered on DPIN in 2004-05. This can only be regarded as the lowest number being prescribed.

Cost

We have no firm information on potential costs, but current expenditure would appear to be at least $50,000 if patients use only one treatment and $107,000 if they use two. Again, these can only be regarded as low estimates.

Other Provinces

We have no information on how other provinces treat this product.

Issues

The main issue here is whether or not Synvisc should be treated as a drug and made available under Pharmacare provisions. It is not currently considered a drug but is, instead, treated uniquely as an implantable device. We feel, however, that it is closer to being a drug than to being a 'device'; it is injected and it relieves pain and facilitates mobility. Our reading of the literature (see the review by the Medical Advisory Secretariat of the Ontario Ministry of Health and Long Term Care, June, 2005) suggests it is a relatively safe product with few side effects relative to alternative treatments, but also that it is no more clinically effective than non-steroidal anti-inflammatory drugs or steroids, but may be effective as an adjunct to conventional care. We feel that it, and any other similar products, should be evaluated by the Manitoba Drug Standards and Therapeutics Committee for possible inclusion as an eligible Pharmacare benefit. The main considerations would be the efficacy of the product relative to its known side-effects.

3. Overview of Main Problems Needing Addressing

Based on the above summaries of devices and the terms and conditions upon which they are supplied, the following general problems would appear to need addressing:

1. **Rapidly Growing Budgets and Efficacy**
   Expenditures on ancillary and related devices/products are rising rapidly at rates that will put severe strains on the Health budget. Unless it can be shown that these expenditures really are efficacious and cost-effective, greater efforts must be made to contain that growth.

2. **The Small Size of Many Transactions**
   For several devices the size of claims is very small and much less than the administrative costs of processing the claims.

3. **The Wide Range and Diversity of Benefits**
   There is little coherence in the structure of benefits payable. Some devices have no payments attached, some have a co-payment; some pay 100% above a deductible, some less than that; some are tied to Pharmacare deductibles and benefits, others have their own specific benefit arrangements. There appears to be little overall logic to this, with explanations long lost in the archives.

4. **Various Claims Mechanisms are Employed**
   There is no single mechanism for claims. Some claims are routed through Pharmacare, most through Ancillary Programs, others through other institutions (RHAs, HSC, CBS, etc). Some claims are submitted by suppliers, others by individual patients. Some rationalization seems called for.

5. **There is no Systematic On-Going Evaluation of Devices**
   Unlike the situation with drugs, there is no structure in existence for the on-going evaluation of the therapeutic, financial or economic evaluation of devices and related products. It is impossible to know, therefore, what the medical and other benefits of these devices might be, how they compare with alternatives, and whether their public provision is optimal or, in some cases, even desirable.

6. **Inadequate Staff Provision for Audit and Evaluation**
   An evaluation structure would need to be supported by staff capable of auditing the funding and utilization of devices, and helping assess the efficacy of those devices.

7. **On-Going Monitoring of Patients**
   In some cases, the monitoring of patients in their on-going use of devices is inadequate. The result is that devices may be underutilized, unutilized or simply not needed. There may also be issues of patient safety involved here.

8. **Price and Supply Issues**
   For many products, the prices underlying fees payable have not been adjusted for some years. This serves as a check on expenditure growth but it exaggerates benefits payable and puts pressures on suppliers. In some cases, there is no clear competitive process for obtaining supplies while in others the technical ability of suppliers is in question. Supply-driven demand is also sometimes an issue.

9. **Appeals Mechanism**
   There is no obvious mechanism available for patients wishing to appeal decisions made with regard to these devices, whether it be coverage of a particular device for particular patients, access to benefits or the amount payable. Such a mechanism would be needed even more if the system is to be more tightly regulated, as recommended below.

10. **Devices versus Drugs**
    Some new products which are not, strictly speaking, drugs, have many attributes of drugs and might be better treated as drugs rather than as devices. A mechanism needs to be in place for determining how best to categorize and regulate such new products.

The recommendations which follow attempt to address the above issues, rationalizing the benefits offered under Ancillary Programs, streamlining the billing system, highlighting the importance of demonstrating and improving the efficacy of devices and confronting the problem of rapidly growing budgets.

4. Recommendations

4.1 General

1. An Ancillary Programs Standards Committee (APSC) should be established to perform similar functions for Ancillary Programs that the Manitoba Drug Standards and Therapeutics Committee (MDSTC) performs for drugs.

2. The APSC would be appointed by the Minister and consist of specialists with knowledge of products covered by Ancillary Programs.

3. The function of the APSC would be to use the best information available to advise on the relative therapeutic and economic value of devices and products to be covered by Ancillary Programs. The APSC would recommend which devices and products would be covered, the maximum price to be covered and appropriate suppliers. It would also ensure that adequate data are kept on program usage, cost and efficacy that would be drawn upon to guide its deliberations.

4. The terms on which devices and products are made available under Ancillary Programs should be streamlined and standardized. All devices and products would be assigned to one of two categories, Category 1 or Category 2 and, within each category; all devices and products would be made available to patients on exactly the same terms.

5. Category 1 devices and products would be made available without any deduction or co-payment at 100% of the cost up to a maximum amount under the fee schedule.

6. Category 2 devices and products would all be subject to a $100 deductible, per product per person but, thereafter, the programs would pay 100% of the cost up to a maximum amount under the fee schedule.

7. In all cases suppliers, not patients, would bill the Department of Health for reimbursement.

8. Sufficient staff resources should be made available to Ancillary Programs to enable a proper audit, utilization review, and product evaluation/efficacy process to be undertaken to guide the activities of the APSC and to inform government policy. This would be especially important in the rapidly growing orthotics portion of the Program.

9. As resources permit, fee schedules and maximum amounts payable should be adjusted for inflation. This should be done with due regard to prices of the specific devices involved, rather than using a general cost of living index. It should also be acknowledged, however, that not adjusting for inflation fully has

been used as a deliberate rationing device and, in some cases, it may be a less undesirable approach to rationing than alternative approaches.

10. An appeals mechanism should be introduced so that the APSC or some other body would allow patients to challenge any administrative decision with regard to access to devices or financial assistance given.

The specific devices and products covered by Ancillary Programs were evaluated and the following recommendations made, having due regard to accessibility, total program costs, administration costs, ease of payment, efficacy and equitable treatment of patients.

4.2 Specific Devices and Products

1. **Prostheses**.
    - Assign to Category 1.
    - The APSC would review all major devices and, where similar devices are available but of different quality and price, designate a **standard device**. Patients would then be given the option of receiving the standard device or of receiving credit up to the price of the standard device for contribution to a device of higher quality and price, with the patient paying the difference.
    - The APSC would determine whether devices could be fitted by certified suppliers only or by both certified and non-certified suppliers and, where non-certified suppliers are deemed eligible, all suppliers would be paid a common fee.
    - Devices would continue to be made available over the same time interval as is currently the practice, subject to review by APSC.

2. **Orthotics.**
    - Assign to Category 2.
    - The APSC would review all major devices and, where similar devices are available but of different quality and price, designate a **standard device**. Patients would then be given the option of receiving the standard device or of receiving credit up to the price of the standard device for contribution to a device of higher quality and price, with the patient paying the difference (both devices being subject to a $100 deductible).
    - The introduction of the $100 deductible will reduce the net cost of this rapidly growing program, mainly by deterring small claims but also by reducing net costs of orthotics. Since no detailed data on usage are available the precise impact is uncertain but cost reduction is unlikely to be less than $1 million. Access to publicly funded orthotics will, inevitably, be reduced, but access under Family Services and WCB will protect the very poor and the poor injured at work. (To be elaborated upon).

- The APSC would determine whether devices could be fitted by certified suppliers only or by both certified and non-certified suppliers and, where non-certified suppliers are deemed eligible, all suppliers would be paid a common fee.
- Devices would continue to be made available over the same time interval as is currently the practice, subject to review by APSC.
- After conducting a utilization review, the APSC should determine whether or not the supply/pricing of any particular, high demand, orthotics might be better managed through bulk buying or tendering.

3. **Breast Prostheses and Surgical Brassieres.**
   - Breast prostheses will be assigned to Category 1 while public provision of brassieres will be discontinued as the benefit paid is less than the cost of administration.
   - The maximum amount allowed on breast prostheses will be adjusted up to compensate for the withdrawal of coverage on brassieres.
   - Prostheses would continue to be made available over the same time interval as is currently the practice, subject to review by APSC.

4. **Telecommunications Devices**
   - Assign to Category 1.
   - The few users of this program would benefit significantly from these changes without a huge cost to the program.
   - Devices would continue to be made available over the same time interval as is currently the practice, subject to review by APSC.

5. **Orthopaedic Shoes for Children**
   - Assign to Category 1.
   - The few users of this program would benefit significantly from these changes without a significant cost to the program.
   - Devices would continue to be made available over the same time interval as is currently the practice, subject to review by APSC.

6. **Hearing Aids for Children**
   - Assign to Category 1.
   - Devices would continue to be made available over the same time interval as is currently the practice, subject to review by APSC.

7. **Artificial Eyes**
   a. Assign to Category 2.
   b. No significant changes to benefits as patient currently pays $75 for cheapest eye and $150 for most expensive.
   c. Devices would continue to be made available over the same time interval as is currently the practice, subject to review by APSC.

8. **Eye Glasses for Seniors**
    a. Assign to Category 2.
    b. Devices would continue to be made available over the same time interval as is currently the practice, subject to review by APSC.

9. **Infant Contact Lenses**
    a. Assign to Category 1.
    b. No changes to benefits.
    c. Devices would continue to be made available over the same time interval as is currently the practice, subject to review by APSC.

10. **Insulin Pumps**
    a. Given the current state of research into the efficacy of pumps, the stringency of selection criteria and level of commitment required of the patient for effective pump use and the limited number of pump trainers in Manitoba, coverage of insulin pumps under The Health Services Insurance Act is not recommended at this time.
    b. The recommendations in the Advisory Note for the Minister for Health on Insulin Pumps, dated November 14, 2005 should be implemented as soon as possible. These call for the drawing up of patient selection criteria and for prescribing and monitoring therapy; studying pump therapy and its training and technical requirements; estimating potential users and costs and, finally, strike a committee to advise on alternative administrative/benefit arrangements for the device, were it to be covered.
    c. In the meantime, consideration might be given to allowing patients to access financial supports for pumps on exceptional medical and other grounds by appealing to the APSC.

11. **Oxygen**
    a. The coverage of Ambulatory oxygen under Pharmacare should be discontinued.
    b. Only those patients meeting the base clinical criteria for the Home Oxygen Program should be provided with ambulatory oxygen by the Province.
    c. For those patients, ambulatory oxygen should be provided free of charge, without a deductible or co-payment.
    d. Funds for ambulatory oxygen should be transferred from the Pharmacare program to the RHAs.
    e. Patients applying for ambulatory oxygen should be evaluated through the same clinical/medical review process governing access to the HOP.
    f. Provision should be made for an appeals process for those excluded from ambulatory oxygen.
    g. The RHAs must devote resources to the monitoring and maintenance of home based oxygen equipment, both static and ambulatory, to ensure safety, efficacy and whether or not patients actually need oxygen.

h. Either ambulatory oxygen should be tendered as part of the HOP tender or zone prices, which reflect transport cost differentials, should be fixed for it.
i. The Province should pay for oxygen conservation devices where usage of oxygen warrants this on the grounds of financial savings.

12. **Sleep Equipment**
    a. An immediate attempt should be made to recover those sleep machines currently not being used by patients, estimated to be perhaps as many as 2,500 of the 5,000 machines outstanding.
    b. Plans to bring level 3 sleep tests/studies back to a public, institutional setting are commended.
    c. The introduction of a one-time $250 deposit for use of machines, refundable within one year should patients decide not to use them, is also supported.
    d. This deposit could gradually be phased out as the introduction of smart cards monitoring usage of machines is extended. With the use of these cards, it will be possible to ascertain those patients not making proper use of machines. At this point clinical intervention or reclamation of the machine would be indicated.
    e. The training of patients in the use and maintenance of machines should continue to reside in the public sector. At the very least, an evaluation must be made of the costs of shifting these functions to the private sector relative to existing costs in the public sector.
    f. Machines would, however, continue to be purchased from the private sector, preferably by tender.
    g. Annual supplies would be made available by the hospital system subject to a $100 deductible per patient.

13. **Synagis**
    a. The role currently played by the Canadian Blood Service should be assumed by the Provincial Blood Program (PBP) with billing assistance from Ancillary Programs if necessary.
    b. Provision should be made for the review by a specialist of each application for the use of Synagis.
    c. Those reviews would need to be informed by a Best Practices Guideline, to be drawn up by the Province.
    d. Where use of Synagis is deemed appropriate, it should be made available on the same terms as it is now, i.e. without deductible or co-payment.

14. **Synvisc**
    a. This 'device' should be evaluated by the MDSTC for consideration for coverage under Pharmacare, as it has attributes of a drug.
    b. Other devices, so designated by Health Canada, having attributes of drugs, should also be evaluated by the MDSTC for consideration for coverage under Pharmacare.

5. Estimated Costs of Proposals

An attempt is made below to put some preliminary estimates on costs and savings that might be involved if the above recommendations were to be accepted. These can only be preliminary because the information required to make more systematic estimates is simply not available. This, indeed, would be one of the functions of an Ancillary Programs Standards Committee (APSC). A second major weakness is that proposals have been made to adjust the prices of some of the devices covered by Ancillary Programs to compensate for inflation since the last time they were adjusted. Since in some cases the last adjustments were over 20 years ago and others over 13 years ago, the full adjustments might well be huge, depending on the device in question. But we have no figures for how large these adjustments might be. It is not just a question of inflation. In some cases, the costs of devices might also have been influenced by falling costs of materials where technological progress has taken place. As well, suppliers may well have reacted to sticky prices by substituting more expensive devices or ones with larger profit margins when meeting the needs of clients. What follows are, therefore, estimates based on the information which is available and they carry the caution that more systematic analysis needs to become an ongoing feature of the daily work of Ancillary Programs. Adequate staff resources need to be made available to make this possible.

Prostheses

The only additional cost would be those for adjustments in fees for inflation as when these are negotiated between MOPA and the proposed Ancillary Programs Standards Committee (APSC), and the indirect costs of running the APSC and providing Health with the staff needed to support the Committee. We would hope that staff would be freed up from other functions within Health but if not, this might cost around $130,000 (two full-time staff with benefits). Against this would be any savings from adopting the 'standard device' approach.

Orthotics

The additional costs would be those for adjustments in fees for inflation as when these are negotiated between MOPA and the proposed Ancillary Programs Standards Committee (APSC), and the indirect costs of running the APSC and providing Health with the staff needed to support the Committee. We would hope that staff would be freed up from other functions within Health but if not, this might cost around $130,000 (two full-time staff with benefits). Against this would be any savings from adopting the 'standard device' approach. There would also be savings from treating orthotics as Category 2 items, i.e. implementing the $100 deductible. If our sample is representative, it suggests that savings could amount to about $350,000 on billings under $100 (i.e. 6.3% of $5.5 million) plus another $900,000 or so from those with bills in excess of $100 (i.e. 69% of around 13,000 patients x $100). There might also be marginal savings on bulk

bought items if these could be tendered or their prices negotiated (this should be looked at whether or not a deductible is introduced).

Breast Prostheses and Surgical Brassieres

The average claim is $124 per year. There will be a saving on brassieres of perhaps 1,150 x 3 x $12.30 = $42,435, while the costs of the prostheses will be raised by this amount for zero net direct saving but some small saving in administration.

Telecommunications Devices

The average claim is about $300 per patient per year. Extra costs per annum would be 30 x $75 = $2,250 on account of the deductible and 30(300/0.8-300) = 30(75) = $2,250 on account of the co-payment for a total cost of $4,500. Any price adjustment would be additional.

Orthopaedic

The average claim is about $37 per patient per year. Extra costs to the Province per annum would be, 54 x $37 = $1,980 on account of the abolition of the co-payment, based on the anticipated number of clients this year. The inflation adjustment would be extra.

Hearing Aids for Children

The average claim is about $2,257 per patient per year and the average cost of the hearing aids is, therefore, about $2,897. Extra costs to the Province per annum would be 100 x $75 = $7,500 on account of the abolition of the deductible and 100(2257/0.8-2257) = 100(565) = $56,500 on account of the abolition of the co-payment for a total cost of $64,000.

Artificial Eyes

The average claim is about $190 per patient per year, suggesting the co-payment currently amounts to $190/0.7 - $190 = $82. Patients would, therefore, pay slightly more, on average, than they do at the moment (204 x ($100-$82 =) 18 = $3,672, which would represent savings to the Province.

Eyeglasses for Seniors

Our recommendations will reduce significantly the number of claimants, as the average deductible plus co-payment is currently $59 (leaving the patient to pay the balance of $254), but is justified as the benefit paid is less than the cost of administration. As well, seniors' benefits have been expanded through the tax system since 2000. The $100 deductible will consist of a $50 payment to opticians plus the first $50 payable under existing benefits. i.e. no cheque will be issued for less than $50, thereby eliminating a good deal of inefficiency. In fact, this proposal will reduce the number of eligible claims by 86% or by almost 16,000 and the amount of claims by 72% or by $460,000. This would represent savings to the Province.

These proposals probably mean that low income seniors would be the losers here since those purchasing the more expensive eyeglasses would continue to receive assistance from Health.

Administrative costs in Health should fall mainly because of reduced claims, but also because remaining claims would be routed through opticians who would collect the up-front $50 deductible.

Adjusting the prices would reduce savings but would need to be done slowly, given the huge costs involved of complete adjustment.

Insulin Pumps

No additional costs.

Oxygen

If all non-HOP patients are phased out of the POP program and all current HOP patients using POP receive it free, then the following rough estimate of costs/savings can be made:

Phasing out Pharmacare benefits for the POP: 1200 patients, $1.3 million.
Less mobile oxygen costs for HOP patients, assume all still qualify for Pharmacare -$360,000
Plus loss of eligibility for Pharmacare benefits by 18% (220 or so) clients, $80,000 (arrived at as 2.44% of an average income of $15,000 p.a = $366 x 220. The 220 patients are those whose claims for Pharmacare would fall below their deductible with the withdrawal of the mobile oxygen coverage. Data from Health).
Increase in respiratory nurses (2) and technician (1), + benefits, travel, etc, -$220,000
Savings on equipment and use of oxygen, say 15% or 3/4 of BC case, for HOP and residual mobile, + 15% of $1.1 m + $0.36 m = $220,000

Net savings = $1,020,000 over time, less any additional demand for mobile oxygen from existing HOP.

The Sleep Program

Equipment: 1,800 additional patients per year, 90% CPAP @ an average cost of $590 = $955,800
10% BiPAP @ an average cost of $4,000 = $720,000
Total Cost = $1,675,000
Less $250 per machine first year and assuming no returns, = 1,800 x $250 = $450,000.
Net Equipment Cost = $1,225,000.

Supplies: 1,800 x 120 = $216,000
Less, $100 deductible = $180,000
Net Supplies Cost = $36,000.

Less deposits on current 1,200 machines per year and $100 deductible for relevant supplies = $250 +$100 = $350 x 1,200 = $420,000 (ignoring the current year's plans of 800 additional machines until funding is secured).

Net costs while machine deposits in force = $841,000

Plus additional costs of staff to train and educate patients in use of machines, plus equipment and supplies inventory management and control, plus administration of $100 supplies deductible and $250 deposits and, if necessary, reimbursement and reclamation of machines.

After machines with smart cards introduced, deposits will fall by 1,800 + 1,200 = 3,000 (ignoring the current year's plans of 800 additional machines until funding is secured) x $250 = $750,000 plus costs will rise by about $100 per machine for the smart card = $300,000. Net additional costs will be $841,000 + $750,000 + $300,000 = $1,891,,000. A one-time provision of $850,000 is allowed for in the Fiscal Stabilization Fund but machine costs are incurred annually.

Synagis

No additional program costs; minor administrative cost increase.

Synvisc

Some additional costs to Pharmacare program if listed, unquantifiable on available information.

The total saving/cost of the proposals is a saving to government of about $1.5 million in the first year of full implementation (see accompanying table). How soon this level of savings is arrived at will depend upon how quickly the proposals can be implemented but also on the timing of the phasing out of portable oxygen benefits as a Pharmacare benefit. Also, as soon as smart cards replace the $250 deposit for sleep equipment, savings will fall by a further $1 million approximately. Further, as yet unquantified savings, should accrue from a much tighter set of standards being laid down for orthotics. As far as possible, any additional staff needs should be met by reallocating staff within Health.

6. Timing of the Implementation of Proposals

The most critical determinant of the speed with which the detailed proposals might be implemented will be: a) the speed of the political process and b) the speed with which the proposed Ancillary Program Standards Committee (APSC) might be established. Most of the proposals could be implemented relatively quickly thereafter, as they involve changes in regulations. Those requiring new billing procedures will vary in timing depending on the number of suppliers and the complexity of co-payments. Synagis should be very quick; seniors' eyeglasses will take longer as the detailed procedures, and especially those around the minimum cheque payable, need thinking through.

Implementation of recommendations pertaining to oxygen would proceed in stages. First, no new patients would be accepted into the portable oxygen program unless already in the HOP. Funds for portable oxygen for those in the HOP would need to be transferred from Pharmacare to the RHAs. Portable oxygen benefits for those not in the HOP would be phased out as quickly as the government deems feasible.

Proposals to reform the sleep program would continue as planned except that the decision to privatize all aspects of equipment use would be revisited and appropriate costing of alternatives carried out. This should not take more than a matter of weeks.

SUMMARY OF ANNUAL SAVINGS/ADDITIONAL COSTS TO PROVINCE*

PROGRAM OR SERVICE	SAVINGS (-) or COSTS (+)	NOTES
ANCILLARY PROGRAMS STANDARDS COMMITTEE	130,000	If staffing needs cannot be met internally
PROSTHESES	0	
ORTHOTICS	-1,250,000	Possible additional savings on 'standard devices'
BREAST PROSTHESES	0	
TELECOMMUNICATIONS	4,500	
ORTHOPAEDIC SHOES	1,980	
HEARING AIDS FOR CHILDREN	64,000	
ARTIFICIAL EYES	-3,672	
EYEGLASSES FOR SENIORS	-460,000	Plus additional administrative savings
INSULIN PUMPS	0	
OXYGEN	-1,020,000	
SLEEP EQUIPMENT/SUPPLIES**	1,000,000	Double this once deposits withdrawn and smart cards used. A one-time $850,000 is allowed for in the Fiscal Stabilization Fund
SYNAGIS	0	
SYNVISC	0	
TOTAL	-1,533,192	

*No allowance is made here for inflation adjustment s to maximum benefits payable

** Net costs to Province will double once deposits phased out.